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ORIGINAL ARTICLES.

Appendicitis.

Read before the Golden Belt Medical Society at Herrington, July 6, 1893,

By L. J. WARREN, M.D., Clay Center, Kansas.

During the past few years, under our improved surgical methods, inflammatory affections of the vermiform appendix have assumed so much importance to the physician and surgeon as to afford an excuse for presenting a paper upon this subject.

The writer does not presume to add materially to the knowledge already possessed, but in the light of our present knowledge desires simply to discuss certain facts in regard to pathology, diagnosis and treatment.

For the excellent work done in this department of medicine and surgery the profession is greatly indebted to Drs. Fitz, Weir, Sands, Gerster and McBurney, whose contributions are largely responsible for awakening present interest.

From the large number of cases met with to-day, in comparison with the small number formerly reported, the conclusion is obvious that formerly many cases failed to be recognized as cases of appendicitis and were treated under a mistaken diagnosis.

Not many years ago typhilitis and perityphilitis were considered the prominent affections of the right iliac fossa, while now they are considered only as secondary to the primary lesion, appendicitis.

A few years since, Dr. R. H. Fitz, of Boston, carefully analyzed 257 cases of perforating appendicitis and 209 cases of typhilitis and perityphilitis, and gave us important information with regard to differentiating the former from all other affections occurring in this region, and has helped the surgeon in establishing certain important points which will be alluded to later on in this paper.

In a study of these cases he found that certain definite symptoms occur in well-defined order, viz.: localized pain, fever (100° to 102°) and circumscribed swelling, which assist us in differentiating appendicitis from other affections, while general abdominal pain, following iliac pain, may be taken as evidence that a general peritonitis has occurred. In sixty per cent. of Dr. Fitz's cases this happened on the second, third and fourth days, showing that a laparotomy to be successful must be performed early or at the very onset of urgent symptoms. Pain is present in a great majority of cases, and may not be limited to the iliac region, but diffused over a greater part of the abdomen, especially in the early stages of the disease.

The point of greatest pain on pressure will be found at the "McBurney point", midway between the anterior superior spine of the ilium and the umbilicus.

Circumscribed tenderness at this point is considered by McBurney as almost pathognomonic of appendicitis.

An oval tumor of variable size, usually small at first, can usually be detected beneath "McBurney's point", but its absence should not exclude the disease. A few cases have marked symptoms of intestinal obstruction. Rigidity of the abdominal muscles on the affected side, McBurney considers an important symptom.

A fæcal cæcitis should be diagnosed from appendicitis by a history of prolonged constipation, late appearing fever, pain of long duration and a doughy tumor of considerable size in the lumbar region.

To help us in the pathology of the dis-

ease, the writer wishes to emphasize the following well-established facts:

1. That the position of the vermiform appendix is extremely variable, as is also that of its attachment, thereby serving to make the diagnosis of appendicitis quite obscure and the surgical procedure somewhat difficult.

2. That the cæcum and appendix are entirely surrounded by serous membrane, and that therefore they are intra-peritoneal.

3. That primary inflammation of cellular tissue in the right iliac fossa is unknown.

4. That all perityphilitic abscesses are of intra-peritoneal, and not extra-peritoneal origin, and are due to an inflammatory process starting from the appendix.

The last proposition Weir confirmed by an analysis of 100 autopsies.

From the history and progress of appendicitis it would seem that this organ is subject to at least two kinds of inflammation — one, the simple catarrhal variety, producing swelling of the mucous membrane and follicles with occlusion of the duct and tumefaction; the other, the ulcerative variety, going on to perforation and accompanied by local and general peritonitis.

There is yet much to learn concerning the simple and more common variety which does not go on to perforation, but usually ends in resolution.

Dr. Fitz states that post mortem examinations show that one in three at some period in their life must have suffered from simple appendicitis.

That these cases are not diagnosed in life is probably due to the lack of characteristic symptoms on account of the appendix being deeply seated behind the cæcum and below the mesentery of the ilium.

The vague and ill-defined pains in the abdomen, accompanied by constipation and symptoms of indigestion and tenderness in the right iliac region, would doubtless characterize most of these cases. Childhood is probably the period of greatest liability to this simple type of the affection.

It would seem worthy of remark that while this milder form of appendicitis may give rise to frequent and painful attacks which incommode the patient, it is not necessarily attended with great risk of life.

The question is, how shall we diagnosticate these simple and harmless types of the disease from the more serious conditions ending in perforation?

We must bear in mind that the acuteness or mildness of the symptoms, general or local, at the onset of the disease is not an invariable index as to the gravity of the case.

One case with a very mild beginning may prove fatal, while many cases of severe acuteness, as indicated by alarming symptoms, may be followed with resolution. Several of the last-named cases have come under the writer's observation — cases where an operation was advised, and in two of which preparations for an operation had commenced, when the symptoms began to show evidence of the amelioration of the disease, and convalescence was soon established.

Therefore, after the physician or surgeon has recognized a case as one of appendicitis, he has much graver problems to solve.

Is it a simple catarrh which will resolve in a few days? Will pus form and ulceration and perforation take place? If perforation does occur, have sufficient adhesions formed to protect the peritoneal cavity? Is there danger of a general or suppurative peritonitis? Shall we operate or pursue an expectant treatment?

These are questions upon the correct answer of which may depend the life of our patient.

The skilled laparotomist, accustomed to open the abdomen on the least provocation, would say: "Make your diagnosis, if in doubt, and answer your questions by an exploratory incision, for there is less risk in an operation, or at least in an exploratory incision, than in the expectant plan of treatment."

If this were done, I fear that often an organ would be removed which was the seat of only a temporary catarrhal obstruction, and the adhesions of an incision would be substituted for the adhesions of a transient inflammation.

That the average patient prefers the expectant treatment, though attended with greater risk, to the operative treatment should not deter the surgeon from laying before his patient the danger of delay, and request an operation, when in the best judgment of the surgeon one is demanded.

Dr. Bridge, of Chicago, has expressed his opinion as to operation thus: "Surgery is imperative in those cases of acute inflammation in the cæcal region with rather protracted high fever that does not show positive evidence of the subsidence within two or three, or three or four days from the beginning." Dr. Fitz makes this similar brief summary: "Operate for urgent symptoms (rising pulse and temperature, increasing distention and spreading pain) with or without tumor." This last is the opinion of a physician and corroborates that of the surgeon.

The severe recurrent types of appendicitis often renders the existence of the patient miserable and depressed, and each return of the disease seems more painful and dangerous. Whether these should be operated upon in the quiescent stage is still *sub judice.*

Yet, it would seem that an operation performed in the interval of the attacks is both justifiable and reasonable as affording a hopeful means of relief, and in the opinion of the writer ought to be advised.

Weir, however, mentions the fact that he had known some ten cases where an operation performed during the quiescent stage had revealed no adhesions, no evidence of peritonitis, and that in nearly all the cases the appendix was apparently healthy.

From the anatomical position of the appendix, perforating appendicitis is a condition of grave importance. The normal appendix is always found completely surrounded by peritoneum, as is also in a vast majority of cases, the cæcum from the ileocæcal valve downward. Hence ulceration and perforation of the appendix without involvement of the peritoneum are physical impossibilities. In all inflammatory action of the appendix, catarrhal or otherwise, the peritoneum has a part, though usually localized about the region of the inflammation.

In the more serious cases adhesions form, thereby shutting off the general peritoneal cavity and localizing the disease, so that when perforation takes place a circumscribed abscess results.

Nearly all the so-called perityphilitic abscesses have their origin in this way through perforation of the appendix.

In all the cases which the writer has seen the inflammatory process has been localized by a walling off of the peritoneum, and all the abscesses have tended toward the surface.

When we consider that the position of the appendix is favorable for the forming of adhesions and the tendency of abscesses to become localized, it would seem that the danger from general peritonitis is overestimated.

Yet, this danger must be considered in every case, no matter how mild; and when it does occur or seems liable to occur, the case demands prompt and efficient treatment by operation as the only means offered to save the life of the patient.

In regard to treatment, I submit the following propositions, all of which I trust will be thoroughly discussed:

1. For catarrhal and subacute appendicitis — expectant treatment, chiefly laxatives, in the form of salines, and opiate in moderate amount if pain is severe.

2. For cases of appendicitis with an increasing tumor, showing evidence that pus is forming or has formed — extra-peritoneal incision or laparotomy, and if pus is found, thorough drainage of the cavity.

3. For cases showing urgent symptoms and an appreciable tumor — exploration with a needle over "McBurney's point" or an exploratory incision.

4. For cases with or without tumor with alarming symptoms, such as persistent vomiting, spreading pain, abdominal resistance and rising temperature, showing evidence of a general peritonitis — a lateral laparotomy should be performed at once, the region of the appendix explored, and, if pus is found, the cavity packed with iodoform gauze and thoroughly drained.

Laparotomy for Peritonitis.

Read before the Eastern Kansas Medical Society at Topeka, July 13, 1893,

W. R. ROUP, M.D., Lebo, Kansas.

Responding to the very urgent request of your secretary, I will proceed to relate the circumstances attending a very severe case of obstipation which led to peritonitis and a laparotomy.

The patient, a Welchman, æt. forty-three years, a plasterer and stonemason by trade, a man of good physique and universally firm health, called me upon the morning of November 18, 1892. He was complaining of slight pain in the right side near or at the ileo-cæcal region. He also complained of being constipated, and informed me that under cathartics his bowels had moved slightly on the morning of the 15th, but not in a satisfactory manner; and that, notwithstanding the fact that he had taken a number of pills and several doses of salts, he had failed to procure an evacuation since the last date.

I made a careful examination, but could find no tumor or other abnormal abnormality. The patient's temperature was normal; the tongue slightly furred; there was complete anorexia together with frequent eructations of gas.

I placed him in the "knee-chest" position, and, using a fountain syringe, injected a half-gallon of soapsuds at a temperature of about 104° F., and had him retain the enema for fifteen minutes. The results of the injection were not satisfactory; however, there was a tinge of fœcal matter and some odor. Encouraged by the appearances, I remained at the bedside and repeatedly administered enemas as before with no further result than an occasional fœcal stain and in a few instances portions of apple parings and apple salts, together with parts of the core and husks or shells from the core covering the seeds.

At length, weary of my task, I ordered a teaspoonful of Roschelle salts administered every three hours, the enemas to be given hourly.

Upon the afternoon of the next day, viz., November 19th, I again called upon the patient to find the conditions unchanged, except that he bore marks of fatigue and unrest by reason of a loss of sleep and the oft-recurring enemas, which had been faithfully given during the entire day and night without other results than an occasional coloring of fœcal matter and a few more shreds or apple parings. Upon inquiry, I found that the ingesta mentioned had been taken into the stomach some twelve days previously when he had met a neighbor upon the wayside, who had apples in his wagon, of which the patient said he had eaten a number in a very hurried manner, as he was cold at the time and engaged in conversation and in haste to go on by reason of the cold, and was of the opinion that he, so to speak, "bolted the apples down."

This brings us to the afternoon of the 20th. I remained with him during the remainder of the day and until 3 o'clock of the next morning, November 21st. I had continued the salts every three hours up to this time and the enemas perhaps every hour or hour and a half. I then had recourse to the inflation of the bowels by hydrogen gas from which I received no other result than that of rendering my patient decidedly uncomfortably. I succeeded in distending the colon very markedly. In a short time the gas passed away without producing any appreciable salutary effect. I then had recourse to massage, continued two or three hours, after which I administered a large enema. During the last number of injections that were given I had been in the habit of inverting my patient completely, having him supported by the legs by two strong men, whilst the injection, consisting of soap, water, lard and turpentine in appropriate proportions to the amount of one gallon, was allowed to flow slowly into the bowels. This was repeated some half-dozen times, but with no more fortunate results than before.

I then asked for counsel, informing my patient that whilst I did not believe there

was complete occlusion of the bowel, that I anticipated an operation would be necessary to restore him to health.

There was one point in connection with the case that I wish to call attention to particularly and that was the apparent absence of any peristalsis of the bowels. I recognized this fact early in the case, and notwithstanding the fact that I made repeated examinations to that end, both with the naked ear and stethoscope, I found the entire field comparatively silent and motionless. This, of course, inclined me to the belief that I had paresis, but as to the exciting cause I must confess that I was ignorant.

In response to my request for counsel, Dr. J. H. Page, of Emporia, Kansas, came to my assistance. After he had been dispatched for, I administered to the patient as a semiderniere resort, ten grains of jallappa and thirty grains hydrarg. chloridii mit., thinking that, l t the case be as it might, unless we had conclusive results before the doctor's arrival, an operation would be speedily necessary.

There had been no rise of temperature up to this time. However, the thermometer now registered 99° and the patient was becoming tympanitic, though in no great degree.

Upon the arrival of Dr. Page, he suggested that we give a tobacco enema, which we proceeded to do by taking about one ounce of strong plug tobacco, steeping it and adding the infusion to a half-gallon of warm water and administering it in the position before named, *i. e.*, the patient being supported by the legs, the head resting upon the floor. This enema was allowed to remain fifteen minutes. It rendered the patient quite sick and very much relaxed, but when it passed away we had naught to repay us for our tobacco save a few shreds of apple parings, an apple seed or two, and a faint fœcal odor.

At the end of an hour we repeated the process with very similar results. Dr. Page then suggested the use of coal oil in the enemas, which was readily agreed to by me, and we gave repeated injections of a half-gallon of water and a half-pint of coal oil, in one of which we were successful in that degree that we were rewarded by some larger pieces of apple core and rinds; a little feculent matter also accompanied the dejection.

At this hour—3:30 A. M., of the 22d—I left the patient, Dr. Page remaining until about 7 o'clock of the same morning. His report was somewhat encouraging, and that after one injection there was more feculent matter and undigestible parts of apples.

I returned to my patient again in the afternoon of the 22d to find that although the salts had been persisted in and the enemas had been continued, there had been nothing in the discharge to lead one to anticipate a happy conclusion.

I found the patient very weary, considerable tympanitis, some abdominal tenderness, a furred tongue, slightly reddened at the sides and tip, and a temperature of 103° F. I discontinued the injections and ordered hot fomentations to be applied to the abdomen, the applications to be changed every fifteen to thirty minutes. Having become thoroughly convinced that an operation alone would be crowned by success, I telegraphed Dr. Page, urging haste. Arriving at Lebo at 7:30 P. M. of the 23d, in company with Drs. Foote and Lusk, we drove to the patient's home at Arvonia, a small village five miles distant.

After a general consultation, an operation was agreed upon for the relief of our patient.

Although I think neither of us was fully satisfied as to the exact pathology, on one thing, however, all agreed: we had peritonitis, whatever might have been the primary lesion, and an operation was agreed on. The patient was stripped, the abdomen and adjacent parts were washed, shaved and scrubbed until the parts were of a bright pink color. The patient was then placed upon the table and anæsthetized, the A. C. E. mixture being used, which he took kindly at the hands of Dr. Page.

As soon as he was well under the influence of the anæsthetic, the parts were again brushed with soap and water, then bathed

with a solution of the bichloride of mercury, 1 to 1,000 after which we had recourse to sulphuric ether, washing the site of the operation freely with it.

I then arranged about the field of the operation towels wrung out of a hot solution of the bichloride of mercury, 1 to 4,000. It is needless to say that our hands had received the necessary cleansing, water, soap, bichloride and ether being used, our fingernails receiving due attention, and all things done to render the operation thoroughly aseptic.

The point selected for operation was about two inches or a little more above Poupart's ligament, and the operation was conducted upon a line therewith.

On reaching the peritoneum, it was picked up, nicked and divided on a grooved director with a probe,pointed bistoury.

At this juncture I found my opening too small for convenience and at my request it was enlarged by Dr. Lusk from two and one-fourth to about three inches with a probe-pointed bistoury whilst I held the viscera from contact with the knife. I then began to withdraw the intestines, looking first to the ileo-cæcal region, expecting to find some lesion there. In this I was somewhat disappointed, for although there were marks of an inflammatory action, I found the appendix vermiformis in a healthy condition and the cæcum itself healthy, save for a diffuse blush on its under surface.

We then proceeded to examine the small intestines, removing, I should judge, twenty feet or more of the same and found throughout that extent more or less inflammatory action, especially on the side of the intestine where we had the mesenteric attachment. In some places the mesentery itself would be deeply engorged; in others, but slightly affected.

The peritoneum was also highly congested and inflamed so far as our field of observation extended. There was, however, no purulent infiltration or effusion. The effusion that did exist, which was not large, appeared to be serum alone. This we readily removed with sponges.

We now turned our attention to the colon, finding it in a more healthy condition with little or no congestion on its surface.

During the time that the bowels were out of the cavity, I kept them carefully wrapped in sheets wrung out of hot water that had previously been boiled and strained through fine linen cloth.

As we had failed to find any definite obstruction or purulent effusion, we did not deem it necessary to wash out the cavity, but proceeded at once to close the abdomen with a drainage tube inserted, using carbolated silk for that purpose.

We then dressed the wound with iodoform antiseptic gauze and absorbent cotton, all of which were well secured by a large roller bandage.

During the operation we had an enormous discharge of gas, fluid and fœcal matter, I am inclined to think principally retained from enemas.

We had no other discharge for twenty hours, when the bowels moved copiously, the matter being feculent and the odor something beyond description.

The temperature, when the operation was made, was 101½° F., and twenty-four hours after, 99° F., soon reaching the normal limit.

During the first two days after the operation, the drainage tube was left in position. The discharge being profuse, I caused my patient to be upon the right side as much as possible to favor drainage. By the third day the discharge had so far ceased that I removed the tube altogether.

The salts which I ordered at the time of the operation were discontinued after the discharge from the bowels last mentioned. From that time forward the appetite improved, the temperature remained normal, the general system regaining tone.

Aside from the fact that outer integuments failed to unite by first intention, even where the drainage tube was not inserted, which required the edges to be freshened and restitched on the seventh day, no untoward symptoms appeared.

The operation was made upon the eighth day from the date of his last stool, and the patient was discharged on December 9th, sixteen days after the operation.

The Odor of the Breath in Mental Diseases.

Read before the Eastern Kansas Medical Society at Topeka, April 13, 1893,

BY

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PROFESSOR OF DISEASES OF THE MIND AND NERVOUS SYSTEM IN THE KANSAS MEDICAL COLLEGE.

In considering the pathological conditions of our patients, it is proper that we not only use the instruments of precision which have come to be regarded as our tools of trade, but also the grosser methods of observation by means of our common senses. Sight, hearing and the sense of feeling are commonly employed in diagnosis, but the sense of smell seldom.

The size and prominence of the olfactory bulbs would indicate an important function which, if properly cultivated, will doubtless prove a greater aid in diagnosis than is generally supposed.

The detection of an odor is left to individual appreciation, as no systematic culture in this direction is practiced.

No description is adequate to an appreciation sufficient to enable us to recognize a new odor, and indeed with the possible exception of the general division of sweet and sour, many of us derive little benefit from our sense of smell.

To those, however, who have a keen nose, the odor of a patient aids greatly in diagnosis.

Diphtheria, having a superficial manifestation of necrosis, is readily recognized by the odor in many cases.

The peculiarity of the odor of the breath, described as fruity in diabetes, is an illustration of the elimination through the lungs of waste matter of the blood in a degenerative process.

Abscess of the liver is attended by a peculiar odor of breath which is to be observed, but with greater intensity at the autopsy.

Other illustrations could doubtless be mentioned wherever the products of degeneration of cells, carried by the blood to the lungs, is mingled with or chemically combined with the urea, carbon dioxide, nitrogen and water of the breath to produce a significant odor.

To those who have had much to do with cases of degenerative disease of the brain, I think an odor can be recalled which remains as a permanent memory of these poor unfortunates.

The first thing that naturally comes to mind is as to whether or not we can exclude emanations from the stomach in a given case.

I am aware that in many cases of mental disease there is fermentation of food, but in many also there is not, and besides I believe a distinction can be made in these odors.

It is true that in degenerative brain disease a very small proportion of cases have destructive processes in the stomach. In Ewald's work on diseases of the stomach, we find in the report of investigations by W. Fenwick that in nearly all diseases studied by him catarrh of the mucous membrane of the stomach was found, except diseases of the brain. In these, including tumor epilepsy, softening and apoplexy, it was not found.

Handfield Jones also, in a study of over 100 cases of affections of the glands of the stomach, only once found diseases of the brain.

One case recently coming under my notice adds something to this idea.

Mr. ———, æt. sixty-four, an old soldier, had been showing signs of mental decline for several months. The senses were dulled. There was a general unrest, attended with moaning, which finally ended in coma and death. The (to me) characteristic odor of the breath was present and had been for several weeks as the family reported.

There was no history of indigestion. On the contrary, the man was able to take solid food regularly and in good quantity, and was well nourished. The teeth were not entirely clean, but nothing of an ulcerative kind was present either in the mouth or nasal passages. I washed the stomach several times and found nothing, the water

returning absolutely as clear as when introduced.

I appreciate that this one case offers little proof, but it serves to corroborate an opinion long entertained and which I hope in future to substantiate by more definite observation.

I take it that the elimination of an odor in the breath does not necessarily imply that the same odor exists in the blood, as the combination in the lungs with the exhaled gases may be the birth of this disagreeable emanation.

The destructive metamorphosis of the convolutional structure reasonably unloads into the blood effete matter which may give distinctive character to the odor of the breath. This is the idea I wish to present for your consideration, and although it is not laid before you in an elaborate manner, I trust you will agree with me that the less said about so offensive a subject the better.

To those who are listening for the precision which science requires, I will say that this is a summer paper, a very thinly-clad thought, seeking standing room and hoping to have more fashionable habiliments later on.

STRYCHNIA is now considered a specific in uterine hemorrhage. It should be administered in one-sixtieth grain doses three times a day for a period of four to six weeks before the time of labor in all cases where there is a history of flooding. It will also prove of value where previous labors have been tardy, due to irregular and feeble uterine contractions.

FOR diabetes Dujardino Beaumetz recommends seven grains of carbolized lithea and two drops of Fowler's solution in a glass of vichy water before breakfast and dinner, sponging the body every morning with warm water, rubbing briskly, plenty of outdoor exercise, and the usual diabetic diet.—*Times.*

SOCIETY PROCEEDINGS.

The Topeka Academy of Medicine and Surgery.

The Topeka Academy of Medicine and Surgery met in A. O. U. W. Parlors, Monday, August 14, 1893, at 8 o'clock P. M.

Meeting was called to order by the president, S. E. Sheldon.

There were present Drs. Longshore, Ward, Pelton, Cannon, Colcord, Mitchell, McClintock, McCasey, Magee, Sheldon, W. E. McVey, Lindsay, Minney, Coldren, Conger, Rodgers, Munn, Alexander, Hibben, R. E. McVey, Barnes and McCrea.

Dr. Magee reported a case of "Optic Nerve Atrophy."

"Mr. C. came to our office three years ago complaining of dimness of vision in the left eye; right eye somewhat affected. On examination I found the difficulty in the optic nerve. He was put on treatment, constitutional and local, the latter consisting of galvanism, alternating current, under which treatment his vision and gait improved to a very marked degree. He continued the treatment until about one month ago, when he returned. The sight in the left eye was worse; that in the right eye about the same. He gives a history of chancre about sixteen years ago, but never had a rash. Some symptoms point to posterior spinal sclerosis, while other symptoms belonging to that disease are absent. The optic disc has a bluish, chalky appearance. Arteries and veins both very much diminished in size. Patellar reflex is absent. Sharp shooting pains in the extremities. In locomotor ataxy, strabismus, ptosis and double vision are the first symptoms. They were not present in this case. The Argyll-Robinson pupil is here. This is a pupil which is not affected by light, but accommodates to near vision. A glass does no good in this case. He has the peculiar gait of locomotor ataxia, and when the eyes are closed and the feet placed together, he

wavers. He never goes without a cane. Muscular power is good and he is a hard-working man. Appetite is good. He gave us a history of syphilis three years ago, and we gave him potass. iodide and mercurials, which he continued for two years, when he stopped. His vision had begun to fail before he stopped. Galvanism does not seem to cause any improvement."

Dr. Lindsay.—"The disease tabes dorsalis is likely to be confounded with multiple neuritis. There is a difference made by some authors between syphilis and tabes dorsalis. The great majority believe this disease is associated with syphilis. The difference between tabes dorsalis and multiple sclerosis is that in the latter numbness takes the place of the lightning pains of the tabes. The three leading symptoms of tabes are common to the other, the Argyll-Robinson pupil, swaying on motion and absence of patellar reflex. Multiple neuritis may be caused by intemperance, lead and diphtheritic poisons, and aside from this it may be the result of treatment. In multiple neuritis we also find atrophy and weakness of the muscles. Atrophy of the optic nerve is not a constant accompaniment of tabes. Allen Starr relates twenty-four cases, in only three of which there was optic atrophy. There are a great many sensory disorders with tabes. All of the columns may be the seat of atrophy, yet not have tabes. The history in this case was the indication for specific treatment, though the result does not prove that it was not of specific origin, but there is probably some other disorder."

In answer to Dr. Minney, the patient said the sight began to improve very soon after the treatment began.

Dr. Magee said he was now getting six grains of iodide of strontium three times a day.

Dr. Lindsay suggested that he be given 200 grains a day.

Dr. Pelton.—"There are several diseases we are likely to confound with tabes dorsalis. In disseminated sclerosis we find optic nerve atrophy, staggering gait, etc. In tabetic paralysis we have symptoms pointing to trouble in the pyramidal tract. In locomotor ataxy we have optic nerve atrophy preceding inco-ordination. In cases of loss of patellar reflex there is failure to benefit. The gait and shooting pains are characteristic of locomotor ataxy. There is a difference of opinion as to the cause. Some claim it is due to syphilis in most cases, others claim it may be due to injury, alcoholism, etc. In alcoholic excess we have a parenchymatous degeneration."

Dr. Minney.—"I would like to ask whether after the calibre of the vessels has been so narrowed it is likely that they can be restored. What is the cause of this narrowing of the vessels?"

Dr. Lindsay.—"If the narrowing is due to specific disease and the dose of the iodide of potassium is carried to the proper point they can be restored. Whatever there is there that is not specific cannot be. I would increase the iodide to 200 grains a day."

Dr. Pelton.—"Gowers claims the changes in the vessels and nerve tissue is not due to specific infection *per se*, and when the change has taken place it assumes the same condition as when due to other causes. When the iodides have been pushed to a fair degree without effect, I would not expect to change the condition of vessels where there has been new formation of connective tissue. The best to be expected is the checking of the progress of the disease. I would use strychnia and nerve tonics."

Dr. Lindsay.—"It seems to me that seven grains of iodide a day is not carrying it to the extent of saying it is of no service. There should be no difference between the smaller vessels and those larger ones of the brain where specific treatment does produce this change."

Dr. Pelton, in answer to Dr. Minney, said: "In diseases affecting the cerebro-spinal centers we have affections of the optic nerve and of accommodation, and it is through the vaso-motor nerves which effects its circulation and nutrition."

Dr. Magee, in closing, said: "When the optic nerve atrophy increases to nearly blindness, inco-ordination is at a standstill; and when the latter increases rapidly, the

dimness remains stationary. Unless sure of a specific cause, the administration of iodides makes the cases worse. Some favor nitrate of silver and faradaism. In this case we find that when his sight improves, his gait improves, and when his vision diminishes, his gait is worse. The gait may be due to poor vision."

Dr. Ida Barnes read a report of a case: "A girl sixteen years old, general neurotic disposition, had complained of backache with pain and tenderness in pelvic region. Irregular menstruation with attacks of epistaxis. Pelvic examination revealed an antiflexed uterus with a very small cervix which seemed much thinned anteriorly at the point of flexion. There was tenderness at the fundus and great sensitiveness of the entire vaginal canal and rectum. As soon as possible a more thorough examination disclosed the right ovary prolapsed so that it could be felt distinctly in the posterior cul-de-sac. Local applications of iodine and the introduction of glycerine packs lessened the sensitiveness. Hot-water injections into the vagina were also used. General treatment for the nervous system and the bending movements of the physical culture exercises have improved the condition of the patient. As there was some error of refraction, glasses had been fitted, but with little benefit as far as the general symptoms were concerned."

Dr. Minney.—"I saw this girl last fall and thought she was a neurotic individual. She had her eyes treated before with little result for good. There was an enlargement of the papilla and distension of the blood vessels. The cause of the trouble was doubtless in the genital organs."

Dr. Ward.—"If this is a case of prolapsed ovary with cure by treatment, I am skeptical. If there has been in this case, or is a prolapsed ovary in the cul-de-sac of Douglass, pain will be caused by a loaded rectum, and unloading this will relieve symptomatically. By treatment the symptoms may be relieved, but a prolapsed ovary is not cured, *i. e.*, put back in its place by this method. I do not approve of any local treatment to the uterus in this case. I do not think she has gained anything."

Dr. R. E. McVey.—"I endorse what Dr. Ward has said. I do not believe local treatment does any good. In these neurotic cases there is more mental trouble than anything else, and the doctor did more by her encouragement than by her local treatment."

Dr. Alexander.—"This strikes me as one of those neurasthenic cases that falls into the hands of the general practitioner. They are more properly cases for the neurologist than the gynecologist. They have sensitive ovaries and are sensitive all over."

Dr. Rodgers.—"There are neurotic cases where we are unable to say just what the cause is, and there is no marked organic or functional lesion, yet they must be treated."

Dr. Barnes.—"In reply to Dr. Ward, I think the ovary was fixed. At first I could locate it and afterward it receded. There were evidences of adhesions, *i. e.*, tearing and straining on manipulation."

The application of Dr. J. H. McCasey, a graduate of the Medical Faculty of the University of Toronto and of the College of Physicians and Surgeons of Ontario, 1887, was referred to the committee.

Society adjourned.

W. E. MCVEY, M.D.,
Secretary.

Golden Belt Medical Society.

The society met in the parlors of the Herrington Hotel, Herrington, July 6, 1893.

There were present Drs. LaFevre and Felty, of Abilene; Drs. Harvey and DeWees, of Salina; Dr. Sawtell, of Gypsum City; Dr. Ketchersid, of Hope; Drs. Money, Southerland and Henlen, of Herrington; Dr. Warren, of Clay Center; Drs. Halley and Block, of Kansas City; Drs. McClintock, Sheldon, Lindsay and Minney, of Topeka; and Mr. C. W. Lyon, of Topeka, representing Tilden & Co.

After the usual routine business, the president, Dr. Felty, gave the general address.

He called attention first to the indifference among physicians to the peripatetic quack, who was favored by the press and the people; the latter through ignorance and the former for lucre. He urged that something be done to correct the evil. One cause of the trouble is lack of education in the profession. He urged physicians not to be over anxious to have a medical student and to patronize medical colleges requiring a four years' course of eight months each. The ease with which men could get into the medical profession in Kansas and lack of law regulating the practice was another factor.

Dr. Hazlet's paper on "Laryngeal Phthisis" was read by proxy. It dealt with the etiology and treatment. The disease might occur in any part of the body. The treatment should be hygienic, medical and surgical. Scraping is practiced in other parts of the body for tuberculosis, and should be done in the larynx, although in the larynx it is somewhat difficult, it can be thoroughly scraped, after which lactic acid should be applied to the part. The part should previously be deadened by cocaine. Of course the vocal cords cannot be so treated. Four cases were reported, treated by curetting and lactic acid. Guaiacol was given internally with good results, although one patient died.

DISCUSSION.

Dr. Sheldon.—"The plan of treatment outlined applies to all cases of tuberculosis. The surgical treatment is indicated where the parts can be reached. The infected part should be removed and the cause so far as possible eliminated. It is not the germ *per se* that causes the trouble, but the ptomaines. While we cannot remove all of the alkaloid ptomaine, we can remove all that can be reached and trust to the resisting power of the system to restore the patient with the help of supporting treatment."

Dr. Halley.—"The question of treatment by local or topical means is a vexed one. The symptoms are different before and after the breaking-down process takes place. A tubercle has no tendency to break down. It does become an irritant and in this way ulceration takes place. The tubercle bacillus cannot live long exposed to the air. The ulcerative process is treated, and not the tubercle. Iodoform and ether injected into the submucous tissue is good treatment."

Dr. McClintock.—"The tubercular tissue does break down."

Dr. LaFevre.—"The disease is not so rare as commonly supposed. From eighty to ninety per cent. of pulmonary tuberculosis will show the larynx to be more or less involved. The lungs and larynx are richly connected by lymph channels. Great advance has been made in the treatment of laryngeal phthisis by combining the surgical with the medicinal and hygienic treatment. The tubercular bacillus will live in dry dust an indefinite time. Coming in contact with the atmosphere does not destroy them. The tubercle becomes imbedded in the tissue and causes irritation. Leucocytes surround it, causing a circumscribed infiltration and swelling. The vitality of the part in this way is cut off, the tissue enclosed breaks down and undergoes a cheesy degeneration. By curetting and applying lactic acid the disease tissue is destroyed and a cure effected."

Dr. Block.—"Whenever the tubercular trouble develops, it is hard to cure or even to ameliorate the symptoms. The diseased tissue must be gotten rid of in order to effect a cure. Curetting the part where it can be reached and the application of caustics, anything to remove the tubercular tissue, is the treatment. In the larynx, tracheotomy is indicated, thus giving rest to the diseased organ, which favors resolution. In tubercular cystitis, cystotomy, physiologically, is good treatment."

Dr. LaFevre.—"Tracheotomy would aid materially in the cure by giving rest to the parts, but the difficulty is in getting the consent of the patient."

Dr. Felty presented a case for advice. The case had been through the hands of several physicians and the doctor was not satisfied that there was any actual disease.

Drs. Block, Sheldon and Sutherland were appointed a committee to examine the case. The committee confirmed Dr. Felty in the

diagnosis of hysteria, although there might be a beginning leucocythemia.

Dr. Harvey gave a lecture on "Dislocation of the Hip-Joint," illustrating his remarks on one of the physicians present. He said: "Never attempt to reduce a dislocation of the hip-joint or even to diagnose it without anæsthetizing the patient." He also advised against the use of the rope and pulley in reducing these dislocations.

Dr. Felty.—"I recall a case where all manipulation failed and the rope and pulley were resorted to successfully. How the accident occurred is important to know."

Dr. Halley.—"A positive diagnosis between a dislocation and a fracture of the neck of the femur is essential. In dislocation the limb is always rigid; there is preternatural immobility and in fracture there is preternatural mobility. An ordinary jack towel placed around the patient's thigh well up and around the surgeon's body is of great advantage in reducing the dislocation in some of these cases. Extension and manipulation can be made at the will of the operator."

Dr. Ketchersid.—"A complication not mentioned is a backward dislocation, the head slipping below and under the orbicularis internus and the muscle wraps around the bone. The head must be gotten above the muscle. This is done by drawing the leg squarely across the body, pressing up and then draw the limb straight out and the head is in this way lifted out."

Dr. McClintock.—"Gunn's rule was to place the limb in the position in which the body was at the time of the injury, and then to reverse the force."

Dr. Harvey.—"I did not intend to give the complications, but the plain, simple, common dislocations. It is the common things in surgery that are sometimes forgotten."

Dr. Sutherland was requested to open the discussion on neuralgia, there being no report on the subject. He said: "Neuralgia is a condition and not a disease *per se.* There are well-marked pathological changes at times in the nerves themselves, but the word neuralgia means nerve pain and is a crying out of the nerve or warning to the patient of trouble. It is only a symptom and the pathological lesion may be obscure. The causes differ widely. A case of fascial neuralgia came under my observation which was due to nasal catarrh. Neuralgia is classified according to its character, *i. e.*, hysterical, anæmic, malarial, sympathetic, etc."

Dr. Minney.—"I do not understand that neuralgia is a disease any more than dropsy or malaria are diseases. Pain is the warning or symptom of a functional or organic trouble. There may be an inflammation of the nerve—neuritis. Many pains are caused by functional or sympathetic trouble. Pain is a calling out of the tissues of a want; it may be for food or from an injury to them from traumatism or a retention of deleterious substances in the blood. There are headaches and neuroses caused by eye strain, but the claims advocated a few years ago, respecting the large percentage of neurotic troubles and headaches caused by eye strain, is not confirmed by the treatment. Some four or five cases of eye pain or neuralgia of the eyes, and one of neuralgia of the ear, have come under my observation during the past eight years, due to phymosis. The children were circumcised and the neurosis disappeared."

Dr. Sheldon urged that things should be called by their right names. "Search for the cause, and when found, the nomenclature is at hand."

Dr. Block.—"In neuralgia there is molecular change. I had a case of neuralgia of the tongue, mouth and buccal cavity. The other organs of the head had been examined without locating the trouble, and an examination of the urine showed abundance of uric acid crystals. This was corrected and the neuralgia was cured."

Dr. LaFevre.—"Did the uric acid cause the pain or was it not the impoverished condition of the blood."

Dr. Sheldon read a paper on "Supra-pubic Lithotomy," reporting some cases.

Dr. Halley.—"I favor the supra-pubic operation in favorable cases, such as described in the paper. The bladder should

be caught up without the mucous membrane in suturing, invert and bring the cut surfaces and under surfaces together, thus preventing the mucous membrane, which is lax in the bladder, from getting between the lips of the wound and preventing union. The low operation is probably better in children."

Dr. Minney.—"I can see the force of Dr. Halley's remarks respecting the mucous membrane getting into the wound. In canthotomies it is necessary to cover the cut surfaces with mucous membrane to prevent union in the enlargement of the palpebral fissure, and if the raw surface is not completely covered, the wound grows together. The objects are just the opposite, but the mucous membrane is the factor in both cases. The drainage tube has been spoken of. Is it not an acknowledgment on the part of the surgeon, when he uses a drainage tube in a clean wound, that he is afraid his work has been septic?"

Dr. Halley.—"No, not an acknowledgment of septic work, but in large, clean wounds even there is more or less sweating of the tissues and often an excess which the drainage tube will carry off, preventing irritation of and swelling of the parts and favor healing. Owing to the condition of the bladder in case of stone, the micro-organism will poison the wound. Drainage through the wound is necessary in such cases, and the drainage tube should be used."

Dr. McClintock.—"I favor the high operation in all cases possible. The low or perineal operation, owing to its proximity to the anus, is bound to be a septic wound. There is always more or less danger of causing impotence and incontinence of urine, and also of stricture. In the high operation these dangers are avoided."

Dr. Block.—"A drainage tube is necessary at times. Thorough drainage can be secured by using a double drainage tube."

Dr. Sheldon.—"Another operation advocated by some is to make an incision down to the bladder, pack the wound and allow it to heal, and then in a few days complete the operation. I do not favor adhesion of the bladder to the abdominal wall. Its after-effects are bad. It is an unnatural attachment. There is always more or less dragging down on the abdominal wall. Hunter Maguire is doing away with the drainage tube. I think salol should be used before the operation and during the healing of the wound—about five grains three or four times a day. It renders the urine non-irritating and aseptic, two conditions highly favorable to the healing of wounds. Where possible, the bladder should be dropped back into the abdominal cavity and the external wound closed tightly and drained through the natural channel."

Dr. Warren read a paper on "Appendicitis".

Dr. DeWees.—"I had seven cases of appendicitis in twelve weeks—six cases in five weeks. Four cases died and three are living. The case in my own family proved fatal. In this case, after the first few days, there were seemingly no symptoms of any gravity. All at once, from perforation, I presume, there was collapse and death within a few hours. The operation should be done early—within forty-eight hours from the beginning of the attack if salines do not give relief."

Dr. McClintock.—"Recurring cases should be operated upon during the interval. Even catarrhal cases may prove fatal and often demand surgical interference. One reason that the percentage of recoveries in medical cases is so large is: every time a case recovers it is credited as a cure. If the same individual has recovered from six attacks and the seventh attack proves fatal, it is reported as seven cases of appendicitis with six recoveries and one death, whereas the case should be classed as fatal. It should be remembered that in some cases the appendix has a mesentery, but the cæcum always."

Dr. Ketchersid.—"Is it not a fact that the appendix and cæcum are always covered with omentum? I have had a number of cases of appendicitis before the operation was suggested and they all got well. Since the operation has become popular, my experience has been practically the same, and I would be puzzled to know when to operate.

Small doses of opium, just enough to control the pain, and large doses of sulphate of magnesia is my treatment."

Dr. Halley.—"The important point in these cases is correct diagnosis. Suppurative appendicitis will end in death unless an operation be done or it breaks externally or into the intestine. Impaction of the cæcum simulates and is often mistaken for appendicitis. Free purgation relieves the impaction. Pus makes itself known by the constitutional symptoms and not always by the pus tumor. Pus forms rapidly when the appendix ulcerates through and is found in the peritoneal cavity. The time to operate is as soon as the diagnosis is made. Waiting adds to the fatality. As to points in diagnosis, the temperature cannot always be trusted, nor pain. If there be tympanitis, there is probably suppurative peritonitis, and death will follow. There is nearly always irregular chills and some sweating. There is pain in the back, extending to the right side and groin. The McBurney point is usually present. It is a tender point midway between the umbilicus and the anterior superior spinous process of the illium. The tumor is small in appendicitis, but larger in impaction or inflammation of the cæcum. For catharsis I prefer small doses of calomel for the first twenty-four hours, followed by large doses of calcined magnesia. In a clean operation the wound can be closed, but drainage is generally necessary."

Dr. Warren.—"Because cases recover it does not necessarily prove that the appendix was not involved. The catarrhal forms recover as a rule, and there is great difficulty in differentiating between the catarrhal form of appendicitis and one caused by a foreign body. When there is pus it should be evacuated. In some cases a localized peritoneal abscess forms and breaks externally, and the tendency is to recovery. In the early stage of the disease there is fever and pain. I had a case in which the McBurney point was well marked, and the case recovered without an operation. It is also difficult to make a diagnosis between appendicitis and cæcitis with perforation."

Dr. Block read a paper on "Some Practical Hints on the Use of Hot Water in Genito-Urinary Surgery."

Dr. LaFevre.—"In connection with this paper I desire to show this specimen of tripper faden, meaning clap thread. You will observe that these threads are composed of small rolls of mucous membrane and indicate ulceration of the membranous portion of the urethra. In chronic cases of gonorrhœa the cocci are lodged deeply in the mucous membrane, and the treatment is nitrate of silver. The tracks spoken of are plugs of mucus squeezed out of the follicles."

Dr. DeWees.—"I use the concentrated solution of nitrate of silver, twenty to forty grains to the ounce of distilled water, and use a few drops on the diseased parts daily. In an emergency, when out of an instrument, I have bent a glass rod the proper curve by heating it over a flame, and it answered the purpose admirably. The danger of breaking precludes its general use."

Dr. Halley.—"I have used silver a long time. I use weaker solutions than in former years—five to twenty grains to the ounce—and only a few drops at a time."

Dr. McClintock.—"We have put antiseptics aside and use nitrate of silver; a few drops at a sitting in these cases of gonorrhœal troubles."

Dr. LaFevre.—"I first determine whether the discharge is specific or non-specific. In the latter but little, if any, treatment is necessary. If there is pain, a mild solution of zinc and cocaine will give relief, and is about the only treatment necessary. In the specific form there should be no topical treatment during the acute stage. Finding the gonococcus is positive proof that the disease is specific."

Dr. DeWees.—"Frequent bathing of the parts with hot water will often afford relief and keep them clean. Enlarging the meatus is sometines necessary."

Dr. Block.—"Do you think, Dr. LaFevre, that you can differentiate between the pseudo-gonococcus and the gonococcus of Neiser?"

Dr. LaFever.—"I think I can."

Dr. Halley.—"Dont Sternberg say he has

found a gonococcus in the urethra (diplococci) which he cannot differentiate from the specific one?"

Dr. Lindsay.—"How do you determine whether these double crescentic-shaped bodies are specific?"

Dr. LaFevre.—"By the long continuance of the disease."

Dr. Block.—"The gonococcus of Neiser is not positive proof of gonorrhœa. True acute gonorrhœa is not cured in two weeks as some suppose."

Dr. LaFevre presented a specimen of a tumor under the microscope called Wood's tumor. It came from a boy seven years old. It was in the left rectus muscle. Such tumors are more or less painful. They are found in muscular and glandular tissue, and simulate the tissue in which they grow. They are non-malignant.

DR. JOHN HOMANS, of Boston, reported a case of ovariotomy in 1888 in a patient eighty-two years and four months old. Four years later the patient was alive and well. He also reports twelve cases of ovariotomy in women over seventy years of age. This is the largest number of such an age accredited to any one operator.

ACCORDING to Dr. Linn, boric acid is coming into more general use in cystitis and typhoid fever. Ten to fifteen grains of the powder is given several times a day in all bladder troubles. The same quantity is used in typhoid fever cases, but as soon as the tympanitis is diminished the boric acid is discontinued.

"WHO makes kittens, Jackie?"

"Why God makes them, Ethel."

"He doesn't make them as He does babies, one by one, but He just says, 'Let there be kittens,' and there are kittens."—*Medical Review.*

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TOPEKA, KANSAS, SEPTEMBER, 1893.

What Shall We Do?

In no department of medical science has there been greater advance than in therapy. To read the literature on new remedies is a task, and to remember the list is impossible. Many of these new therapeutic agents are valuable, and the wide-awake doctor wants to keep up with the times. In such a case what shall he do? We cannot tell him what to do so much as what not to do. He must not throw aside tried remedies of merit—agents with which he is familiar in a critical case—to try new remedies with which he is not familiar, and the physiological and therapeutic action of which is not generally agreed upon. A new remedy, like new wine, is lacking in one essential—age. Not that age makes pheduretin, the new diuretic or teucrin, the new lymphagogue more effective, but it requires time before all of the findings for and against the agents can be known, and the experience of a large

number of men obtained to establish their therapeutic value and to become acquainted with their toxic effects. It should always be remembered that an agent which will produce a profound effect upon the system is a dangerous remedy to use promiscuously, and that its use must always be guarded. We should acquaint ourselves with the leading therapeutic agents or classes if time permits, but it is better to be master of a few leading agents than to have a general knowledge of many.

A man can practice medicine intelligently with a little definite knowledge of drugs, but glittering generalities in materia medica will bring him to grief.

MORAL: 1. Hold fast to the old that is good and add to it as fast as it is possible, consistent with safety.

2. Do not be afraid of being called an old fogy if you have been diligent in the use of time in informing yourself, because you have not had some hair-breadth escapes or killed a patient by experimenting with a new remedy.

Modern Education.

An English writer in a work on modern systems of education uses the following vigorous but truthful language: "Englishmen who have attained the highest distinction in science have done so not by dint, but rather in spite of their training at school and university. What should we not accomplish were we not handicapped by the miserable pedantry which clings to us like a leprosy? The book of Nature is forever sealed because *teachers*—save the mark!—disdain in their puny imbecility of ignorance to know or teach aught of the laws and powers that animate this awful cosmos; sedulous alone to instill the genders of Latin nouns, the right pronunciation of Latin quantities, the genealogy of rascally scamps that never lived, the names of Trojan ships, the lewdness of mythic gods, and a thousand and one co-equal frivolities and trifles. 'These are thy gods, O Israel!'"
—*Omaha Clinic.*

Acidity of the Stomach.

This disorder should be treated by the administration of acids before meals, preferably hydrochloric, which acts as a stimulant to the mucous membrane of the stomach, thereby permanently correcting the acidity. Antacids should not be used as they only give temporary relief and increase the tendency to acid formation.

WE presume the leaders in the organization of the Association of American Medical Colleges had in view the advancement of medical education and a better standing of American physicians among those of other nations. But, whatever the intentions of its promoters and whatever the remote results may be, the present outcome is a very marked rivalry among the colleges in their ambitions to secure a larger number of students. Various devices are resorted to to evade the requirements to which they have subscribed as members of the association. The Latin requirement, a monstrous bugbear to the whole fraternity, is being evaded in various ways. A certificate of matriculation, an attendance of a few days upon some lecture course are held sufficient qualifications to admit a student to the second year. These practices are not as some might suppose, most common among the smaller schools. It is the larger institutions, those to whom the smaller institutions look for guidance, that have been the most guilty. It behoves the medical profession, who favor higher medical education, to look well into the matter. Some of the State Boards have already notified some of these colleges that their requirements were not up to the standard, and their diplomas would not be recognized. It is but justice to the student that the colleges live up to the requirements of the various State Examining Boards.

THE Anti-Spitting Society is among the latest.

Too Much Importance Attached to the Tonsils.

In the experience of Dr. Farlow, (*Boston Medical and Surgical Journal*) treatment of the nose and post-nasal space is productive of more good to the pharynx and tonsils than treatment of the tonsils is to the nose and post-nasal space. He believes that the days of wholesale slaughter of large tonsils, without regard to structures higher up, will some day have an end. He presents the following conclusions: 1. Because the tonsils are easier to see than the nose and post-nasal space is no sign that they are more important than the latter. 2. Form no estimate of the size of the tonsils unless you see them in repose. 3. Always examine the back teeth and the base of the tongue. 4. In acute follicular disease of the tonsils, look for and treat disease of the other follicular tissue in the throat. 5. Nasal obstruction, cough, and impaired voice are much more likely to be due to nasal or post-nasal hypertrophy than to tonsillar. 6. The fact that the tonsils are enlarged or deceased should lead us to look for a possible explanation in the parts higher up. 7. Free the nose and post-nasal space in addition to, or instead of, tonsillotomy, if you wish to improve the voice and respiration.

Treatment of Sprained Ankle.

Dr. V. P. Gibney advocates (*The New York Polyclinic*) the treatment of sprained ankles by the use of strips of adhesive plaster. Dr. Gibney owes his indebtedness for the new method to a little book by Mr. Edward Cotterell, of the University College Hospital, London. It was not until the end of 1888 that the treatment advocated in the brochure was fully digested and put into use by Dr. Gibney. He had all through his previous surgical career looked upon a sprain as a kind of mystery "not always so bad as a fracture, but sometimes more tedious," requiring fomentations for a little while, then a fixed dressing of plaster of Paris or silicate of sodium, crutches perhaps, and rest and massage afterward. He had never been attracted toward these methods, and he had come to expect a "stiffish" joint in nearly every case that came under his charge. His first case to be tried according to Cotterell's plan was that of a lady who had wrenched her right ankle severely. The usual external features of a sprain were present; no dislocation or fracture could be made out. Dr. Gibney first cut strips of rubber adhesive plaster about half an inch in width and long enough to completely encircle the foot. Then, with the foot well raised, he strapped it (the ankle) and the lower third of the leg with these strips, very much as if he had had an ulcer to treat. The first strip was carried over the outer side of the foot from near the base of the little toe. The second strip crossed the first, the third lapped over the first, the fourth overlapped the second, and so on, until at the conclusion he had practically constructed a Scultetus's bandage of adhesive strips extending far enough to include the lower third of the limb. Over this he placed a cheese-cloth bandage to help the plaster strips to adhere to one another and to make the dressing more tidy. The patient was told to put on her stocking and shoe and to walk about the room. The walking was accomplished with some diffidence, but with no real difficulty. She was made to walk the next day and went out shopping without any bad results. The recovery was without relapse, and the usefulness of the ankle-joint was unimpaired.

In England, second-hand clothes are called "left-off clothes." The following announcement is in a show window in an English town: "Mr. and Mrs. Brown have left off clothes of every description, and invite your careful inspection."

SUBSCRIBE for the JOURNAL.

Cholera: Its Prevention and Treatment.—Surgical Irrigation of the Intestines and Peroxide of Hydrogen (Medicinal).

BY ELMER LEE, A.M., M.D., CHICAGO, ILL.

(Reprint from The Chicago Clinical Review, April, 1893.)

A mass meeting of physicians for the consideration of the above subject was held at the Great Northern Hotel, Saturday evening, March 18, 1893, under the auspices of the Practitioners' Club of Chicago. There was a large attendance.

Dr. C. D. Wescott called the meeting to order at 8:30 P. M., and Dr. DeLeskie Miller was chosen chairman of the meeting in the absence of N. S. Davis.

Dr. Miller, in his opening remarks, said: "This is an unexpected honor to be called upon to fill the place of the gentleman who is unavoidably absent; but as the chairman of this meeting is to be little more than a figurehead, I will accept the honor with thanks. This is an important meeting, and I trust that the attention and interest of it will be given to the gentlemen who will occupy the time. Without further remarks we will proceed to the business before the meeting."

After remarks made by several medical gentlemen on the different phases of the subject of cholera, Dr. Elmer Lee, of Chicago, read the following paper:

"The leading propositions suggested and tried in the treatment of Asiatic cholera during the epidemic of 1892 in Europe consisted of the following general plans: Early in the epidemic, lactic acid treatment was proposed on the ground that it would neutralize the alkaline accumulations in the bowels and so stop the multiplication of the bacilli.

"An Englishman residing in Paris considered cholera a hyperæmia of the spinal cord. His proposition was ice poultices continuously applied to the region of the whole spinal column. A small pamphlet was published by the doctor in defense of his conclusions and to present testimonials in favor of his congestion theory. As this system of management was not seriously considered by cholera physicians, its efficacy cannot be stated.

"The use of large doses of the Russian remedy, salol, the invention of Prof. Nenski, of St. Petersburg, grew in favor as a new remedy during the epidemic. The average result of cases so treated in St. Petersburg, and by my American colleague, Blackstein, in Baku, and in other provinces in Southern Russia, could not be said to be satisfactory. Finally, at thel ast of the epidemic, its influences had come to be considered less and less valuable—this, however, can be said—it was in all and all more largely used than any other new remedy. Still it would not be safe to place too much trust in it.

"Calomel was everywhere a remedy even more used than salol. Formerly this drug was used in very large doses, but last year it was the very small doses which found favor. Especially was this true in the treatment of cholera in Hamburg.

"Of the surgical measures, the infusion of solutions of salt were most practiced. The solution consisted of distilled water in which was dissolved one-half of one per cent. of common salt. This liquid was warmed to the temperature of the blood and either introduced directly into some large vein or injected with a long needle and a large barrel syringe beneath the integument of the abdomen. The amount of salt solution used in either case would be from one pint to one quart each time. In one case treated at Hamburg, as much as thirteen quarts of salt water were used from first to last. The patient recovered. The subcutaneous injections were frequently followed by cysts, and sometimes abscesses appeared. Intravenous injections sometimes proved a godsend, but more frequently disappointment could be said to be the result. These injections were only used in the third period of the disease or the stage of collapse, algidity or asphyxiation, at which period it would be rather unreasonable to expect recovery by virtue of any treatment.

"The Italian treatment, as it was called in Russia, was much used, and with frequent

gratifying success. This practice was introduced by Prof. Cantani. It consists of a clyster composed of the following constituents:

"Boiled water or infusion
of chamomile, (warm)..2 litres.
Tannin.....5 to 10 grams.
Laudanum.....30 to 50 drops.
Powdered gum arabic...50 grams.

"This or some part of the solution is occasionally passed into the rectum to be retained, if possible, by the patient. In the experience of those who have followed this method of treatment almost every case taken at the beginning of the disease has lived. It is certainly more reasonable in principle than simple medical management.

"Of the experiments of Ferran, of Spain, and Hoffkine, of the Pasteur Institute, much has been said, but what has been said has failed to bring conviction to my mind. As cholera itself cannot be said to protect one who has had the disease and recovered, against a second attack, then that which is less than cholera in influence cannot be expected to do it. The seat of the disease is located in the intestines, and, so long as the infectious juices are there, the lymph vessels in the processes of physiological function will continue to infect the blood. Can we hope to thwart physiological action of absorbents by hypodermatic injection of cholera culture, made at some time, it may be years previous to the date of the passing epidemic? The answer by my judgment is that such expectations are flimsy. The caprice of Stanhope at the Hamburg Hospital cannot seriously pass for an argument in favor of anti-choleraic vaccination. His interesting but wildly exaggerated stories were the product of a newspaper's love for sensation and profit of increased sales of newspapers.

"My own personal thoughts concerning cholera and the method of treatment as practiced by me both in Russia and at Hamburg during the epidemic of 1892 will occupy the remaining time allotted me.

"It is now well known that cholera is a disease of the alimentary canal. Its inciting cause is believed to be a germ taken into that canal through the medium of food and drink. There its presence is protested against by the absorbent vessels which eliminate from the food the nutriment for the body. The first symptom produced by foreign invasion in the intestines is a diarrhœa which may precede vomiting from one to three or even four days. If this be true, the bowels must be the seat of disorder, and the most direct method of reaching them by medication must be the best. If the stomach could be emptied of the foul material before the poison has passed further there might be speedy relief and, indeed, no real cholera. After it has passed into the intestines, medicine administered through the stomach may be slow in reaching the seat of the disease, and even then can only mingle with the poison, holding out the hope that the one will be neutralized by the other. This hope in truth, is seldom realized. But if the poison can be removed from below, the course is left clear for nature to recuperate itself. The diarrhœa is an evidence of the great exertion put forth by the organism to rid itself of the death-dealing agency, and probably it would be effectual in the great majority of cases were it not that the nervous forces of the system are exhausted by the terrible strain before the required evacuation of the bowels is completed. A large irrigation of hot water, made soapy preferably by neutral liquid soap, introduced into the colon through a suitable rubber tube, is the simplest, and I am prepared to say further that it is a more satisfactory way of treating cholera than any other with which I am acquainted. The time to begin the irrigation is at the very earliest possible moment. Save the blood every single moment of infection by immediate action, even if there is the faintest suspicion of cholera either with or without diarrhœa. In every post-mortem seen by me of cases of death in which there had been no marked diarrhæa, the colon and small intestines were filled with accumulations of choleraic matter which swarmed with comma bacilli. The rule from which there need never be deviation is to treat the patient by irrigation of the bowels and rinsing of the stomach, without waiting for confirmation of the diagnosis either with the

microscope or by the culture test. The best part of the practice is always to save the patient, even at the expense of fine statistics. The accompanying illustration explains the manner of using irrigation of the intestines. Such apparatus is suitable for places of public treatment of the sick. In private practice the syringe would take the place of the irrigating apparatus. The exact model of the irrigating table used by me in St. Petersburg may be seen at Mr. Sargent's store on Wabash avenue.

"For internal treatment my experience taught me that the *medicinal peroxide of hydrogen, of Marchand*, given in cupful doses of the strength of four per cent. or even much stronger was a better antiseptic than any other drug heretofore known in the treatment of cholera. Then the treatment would be, first, immediate irrigations with hot water and soap, using from one to three gallons at a time twice a day for the first and second day. Once a day afterwards, if required, which is seldom the case. At the same time cleanse the stomach with *medicinal peroxide of hydrogen* and hot water used freely — by urging the patient to drink. The feeding and nursing are the same as would be required by a patient suffering from septicæmia or other prostrating disease. My belief is based upon personal experiences and the following surgical measures and medical treatment, viz.: Irrigation of the bowels, *always first* with hot water made soapy with neutral liquid soap or a good castille soap; second, cleansing and rinsing the stomach with hot water and *medicinal peroxide of hydrogen, of Marchand*, continuing till it is well washed; third, food and nursing; fourth, *medicinal peroxide of hydrogen of four per cent. strength*, given in cupful doses at intervals of two hours during the sickness till convalescence; fifth, meet the requirements as they come up, as would be done in any other grave disease, using whatever personal experience has taught us to believe is good. Cleanse the bowels, wash the stomach, feed the sick, keep them warm if cold, and reduce excessive heat by the cool bath rather than reliance upon drugs; using anything in an emergency that is the easiest and most accessible to procure. The cholera patient may be convalescent inside of the first few days, or if not convalescent and not dead, the case goes into the typhoid state, after which convalescence may be deferred for several weeks or death may be the conclusion. The temperature, prior to the fifth day, is generally subnormal or a little above, but on the fifth day marked exacerbation and elevation of temperature indicates the typhoid condition."

THE CHAIRMAN: "It is a most fortunate circumstance that we are alive to-day. We must all of us feel confident that we have passed from the old to the new dispensation which cannot but strengthen our faith like the anchor cast within the vale. We know what cholera is; we know that we can limit its spread in our city. This is great confidence, and it will do much for the comfort of this community. This idea should be spread throughout the length and breadth of this great city.

Sexual Crimes Among the Southern Negroes Scientifically Considered.

Dr. Hunter MaGuire, of Richmond, Va., in an open letter to G. Frank Lydston, of Chicago, asks the latter to give some scientific explanation, if possible, of the sexual perversion of the present day. Dr. MaGuire says:

"Before the late war between the states, a rape by a negro of a white woman was almost unknown; now the newspapers tell us how common it is. The crime of a negro assaulting a white woman or female child seems to be growing in frequency. Death — certain, swift and merciless — is the penalty. This is the unwritten law of every community in the south; from it there is no appeal. It is immutable, and is sustained by every living white in the community in which the crime occurs. I am not engaged here in defending this law, although it is easy to do it. I am trying only to give you

some facts on which to base your opinion in a purely scientific discussion.

"In the south the negro is deteriorating morally and physically; and, as the American Indian, the native Australian, the native Sandwich Islander and other inferior races, disappear before the Caucasian, so the negro, in time, will disappear from this continent. It is only a question of time. All history, from the days of early Rome, shows that no inferior race, without amalgamation, can exist for very many years in contact with the dominant white man; it is the frightful 'survival of the fittest.'

"The ingenious census bureau tells another story, you may say. Well, the ingenious census bureau has for many years been telling many stories, and this is, just now, as far as it is worth while to discuss this point.

"During the days of slavery, insanity was very uncommon among the negro race. Now our large asylums are not capacious enough to hold the insane negroes of both sexes.

"Before the war the negroes were fed upon the food which of all others conduced to their health; 'hog and hominy' was the main ration, and with this an abundance of bread, milk and vegetables. Now their thriftlessness makes them sometimes suffer for a sufficiency of food, and that obtained is not always of a suitable kind. Many of the most improvident have scarcely enough clothes to hide their bodies, and when able to buy, they generally select flashy and thin flimsy garments that poorly protect them from wet and cold. Their clothes are very different now from the thick, warm homespun they formerly wore. We have also intemperance, excess and impure air from overcrowding and want of ventilation, adding their share to the trouble. Mental depression and anxiety are also common. Laughter and music, universal with them before the war, are now rarely heard. There are many and very notable exceptions to the above, of course, but I am describing the negro masses.

"In this state, during the period of slavery, 'scrofula,' as the word was then understood, was a frequent affection among the negroes. It was shown by the swollen glands, by the tumid belly, by certain ophthalmias and cutaneous eruptions. The negro was called 'scrofulous,' and considered disfigured, rather than disabled. Pulmonary phthisis and other purely tubercular diseases, while common enough in the mulatto, were comparatively infrequent in the negro. Now, however, scrofula in the negro seems to have terminated in what has been called its 'essential element,' and tuberculosis is fearfully common. (I use the words in the senses in which they were then employed.) It is difficult to find in a dissecting-room a negro subject free from tubercular deposit. Another disease that I will only mention—syphilis—is frightfully common.

"I cannot speak of the negroes who have moved to the north and west. I have no means of definitely knowing their condition.

"If, in treating this subject, some other besides a scientific view is necessary for its complete consideration, don't hesitate to use it."

Dr. Lydston answers in part:

"The term 'sexual perversion,' as applied to the class of crimes committed by the negro to which you allude, cannot, in the strictest sense of the term, be justified scientifically. Sexual perversion, in the abstract, implies an aberration of the sexual passion which impels to abnormal methods of gratification with the opposite sex or methods (necessarily abnormal) with the same sex. The only qualification in the case of ordinary rape is that involving criminal assault upon children. Here, strange to say, we often find a class of cases where the criminal has no desire for female adults, but for female children only. I, of course, cannot exactly say how frequent such cases are among negroes, but I firmly believe them to be relatively more frequent among the white race, in whom it may be either inherent or acquired. Rape, however, under the stimulus of this abnormal passion, is not so liable to be perpetrated by the white man for the reason that certain inhibitory influences, such as pride, fear of punishment and ordinary self-control are more effective in the

white than in the black race. Relative to this form of sexual perversion, I will call your attention to the *Pall Mall Gazette* exposures in London some years ago.

"I might remark in passing that, notwithstanding the horrible crimes perpetrated under the influence of the *furor sexualis* by the negro, particularly in the south, I believe that he compares quite favorably as regards sexual impulses—taking all abnormalities into consideration—with the white race. The more I see of white men in so-called refined society, the more contempt I have for quite a large proportion of male humanity. This may not be relevant to the subject under discussion, but still it is worthy of consideration.

"In a recent conversation with an intelligent prostitute, who happened to be under my professional care, I was informed that the men who seek houses of ill-fame for the purpose of having their perverted sexual impulses gratified, are chiefly to be found among the high-toned clubmen and ultra-fashionables. When we consider the favorable circumstances under which such men are placed as regards inhibitory influences, the excessively developed sexual propensity of the negro, while horrifying in its criminal results, is not more appalling than the sexual crimes of his white brother.

"In considering the special causes which account for the frequency with which the crime of rape is perpetrated by the negro in this country, several factors must be taken into consideration."

He suggests the following:

"*1. Hereditary influences descending from the uncivilized ancestors of our negroes.*

"*2. A disproportionate development of the animal propensities incidental to a relatively low degree of differentiation of type.*

"*3. A relatively defective development of what may be termed the centers of psychological inhibition.*

"This defect is characteristic of all races of a low grade of civilization and a relatively low grade of intellectual development. This with some races might in time be corrected, but it certainly has not yet been corrected in the case of the negro, nor do I think that it ever can be corrected in the negro as a distinctive racial type.

"*4. Physical degeneracy involving chiefly the higher and more recently-acquired attributes, with a distinct tendency to reversion of type, which reversion is especially manifest in the direction of sexual proclivities.*

"*5. The removal of certain inhibitions placed upon the negro by the conditions which slavery imposed upon him; these were removed by his liberation.*

"*6. An inherent inadaptability to his environment both from a moral and a legal standpoint, the result of this inadaptability being an imperfect or perverted conception of his relations to his environment—i. e., to the body social.*

"*7. An incapacity of appreciation of the dire results to himself of sexual crimes.*

"You will pardon me, I am sure, when I say that the seeds of religion sown upon the soil of ignorance and superstition characteristic of the negro have had much to do with the development of criminality in the negro race. I sometimes wonder whether no religion at all would not be better than any religion for a large proportion of individuals among the negroes. It is said that most executed criminals go from the scaffold straight to heaven. I doubt whether there ever was a negro who did not believe that he was heavenward bound as he stood upon the scaffold or confronted the righteous indignation of the citizens of the community in which he had committed an outrage. We have not so very far to look backwards from the pious and superstitious negro upon the scaffold, who believes that he is on the short-cut to heaven, to the Zulu, who in battle courts death because the heathen religion of his fathers has taught him to believe that an eternity of happiness lies just beyond his enemy's spear or bullet.

"Again, the northern negro has necessarily been surrounded by more inhibitory influences than the negro of the south. The lower class of whites with whom he has most frequently been brought in contact have been better situated as regards opportunities for honest industry. They have been by virtue of the climate more energetic,

and this necessarily must have had a certain degree of influence upon the negro. The north has been more prosperous, and consequently the opportunities for obtaining a comfortable subsistence have been better for the negro than in the south. The negro of the north has not been so much subjected to the mass influence—*i. e.*, he has been more individualistic than in the south, where large numbers of negroes are found together. In order that civilization should have a fair chance to influence the negro, he must have more opportunities for segregation than in the south.

"The enormous increase of the negro since the war has had much to do with his physical and intellectual degeneracy, and therefore with his criminal propensities. As man descends in the scale of differentiation, the number of offspring at a birth approximates the multiple pregnancies of the lower strata of animal life. Morel, De Monteyel, Magen and one of our most eminent American writers, Kiernan, have conclusively shown that multiple pregnancies are most frequent among the degenerate types of humanity. The offspring in such multiple pregnancies are defective from an obvious double cause; upon them all degrading influences act with greater power.

"You speak of the 'unwritten law of every community in the south, from which there is no appeal.' Now, my dear doctor, what has been accomplished by this law? In answer to this question, I have only to quote your assertion: 'Sexual crimes on the part of the negro in the south are becoming more and more frequent.' This is all, I believe, that it is necessary for me to say with regard to the general utility of the practical application of your 'unwritten law.' I do not say that lynch law is always ineffective, for I spent the earlier years of my life in a community in which it was most decidedly so. One of my earliest recollections was that of the exploits of vigilance committees and those decidedly informal trials held by Judge Lynch in the early days of the history of California—my native state. The conditions, however, which prevailed at that time were decidedly different from those which prevail in the south. Judge Lynch has accomplished great good in many isolated instances in this country. It has only been in isolated instances, however, and under special and limited conditions, such as those involved in temporary emergencies, due to local lawlessness. Lynch law, however, has seemed to have too large a contract upon its hands in the southern states, as far as the acts of lawlessness at present under consideration are concerned.

"Before going further, perhaps it might be well for me to place myself upon record as opposed to capital punishment, legal or illegal. From a sentimental standpoint? Most emphatically no. From a utilitarian standpoint, I have failed to see wherein capital punishment has, in the aggregate, repressed those crimes for which it is prescribed. The census returns show the lowest proportion of capital crimes in this country is in the three states in which capital punishment has been abolished. Even in the olden days of public and bloody executions capital crimes were none the less rampant because of those executions. On the contrary, capital punishment seemed to have a direct effect in increasing the savagery of and lessening the respect for human life entertained by the body social. No matter how scientifically and legally an execution may be done, it is still a sacrifice of a human life, and as such has a demoralizing effect upon the community. If, then, this be true, and capital punishment fails of its object, wherein can it be condoned?

"I object to any method of punishment which is followed by forgetfulness on the part of surviving prospective criminals. With them current events soon obliterate all recollections of the criminal, his crime and its punishment.

"To my mind there is only one logical method of dealing with capital crimes and criminals of the habitual class—namely, *castration*. This method of punishment leaves behind it evidences which will prove a wholesome warning to criminals of like propensities. It prevents the criminal from perpetuating his kind. The murderer is likely to lose much of his savageness; the

violator loses not only the desire but the capacity for a repetition of his crime, if the operation be supplemented by penile multilation according to the Oriental method. A few emasculated negroes scattered around through the thickly-settled negro communities of the south would really prove the conservation of energy as far as the repression of sexual crimes is concerned. Executed, they would be forgotten; castrated and free, they would be a constant warning and ever-present admonition to others of their race. Thus I believe that castration would be peculiarly applicable to the class of criminals under consideration; while, at the same time, claiming that it is the rational method of dealing with the crime question in many of its phases.

"I cannot leave this subject without allusion to your remark that the moral and physical degeneration of the negro will eventually destroy the race upon this continent. This, I think, is true; but it is not, after all, a remedy worthy of consideration, for the more degraded a race becomes the more frequent crimes against law and order will become. While perhaps it would not be desirable to prevent the inevitable in the case of the negro, there might be much of benefit to ourselves in retarding the march of the inevitable as long as we can by improving the physical condition and intellectual status of the negro race. Manual training and education will do much for the negroes of the south; and if our government in the past had paid more attention to these factors in the development of the negroes, who were suddenly thrown upon their own responsibility, and less attention to the cultivation and harvesting of the negro vote, it would have been far better for the south.

"A point well worthy of attention in seeking to remedy the evils which so vitally interest the southerner is this: Much may be done with the negro by a proper example on the part of the white race, which must of necessity be his model, socially, politically and morally. Ignorance of sexual physiology has led the average white boy, at the age of puberty, to believe that fornication is a necessity; or, at least, a luxury at which the whole world winks. You know only too well the train of misery following the indoctrination of such ideas. This fallacious idea is responsible for much of prostitution and sexual crime. Parents abhor its discussion; physicians abhor it as a *bete noir*. Sentimentality and morals aside, the most materialistic of us must acknowledge that sexual purity is wholesome in its effects. The remedy for the evils of youth and early manhood is, never to begin indulgences that create physical and injurious necessities.

STRYCHNINE is not only a good heart tonic, but an excellent uterine tonic. It should be given in one-sixtieth of a grain dose three times a day a few weeks before confinement in case of a history of flooding, or in a case of hemorrhagic diathesis.

SURGERY.

Appendicitis.

My idea of the pathology of appendicitis differs quite materially from the accepted opinion of to-day. The way I differ from other operators is that they operate upon cases of catarrhal appendicitis and find inside of the appendix an ulcer which extends through the mucous and muscular but not through the peritoneal coats; while I have not found a case where the peritoneal coat was left, but I have found cases which resemble that condition where there had been an ulceration and actual perforation which had been sealed over by a plastic layer that could easily be mistaken for the peritoneal coat. I do not at all deny that there are cases of catarrhal appendicitis. The wonder is that they do not occur in every individual.

It occurs to me that the majority of cases of catarrhal appendicitis do not come under the observation of the surgeon; that they are the ones that go on from time to time,

having recurrences, and while they remain as simple catarrhal appendicitis, go on to recovery; but that the cases which the surgeon usually meets with are of one of two varieties:

1. Where a foreign body has lodged in the appendix, and by its size or from the fact that a swelling of the mucous or other coats of the appendix has occurred, stasis has followed, resulting in gangrene of the appendix or a portion thereof.

2. Where ulceration, producing perforation of all the coats of the appendix, has occurred.

This perforation may have been sealed over by the exudation spoken of above, but it is one or the other of these conditions that the surgeon has to deal with. In my limited experience I have never found any other condition. Even when either of these conditions are present, when gangrene or perforation has taken place, the immediate outlook is not hopeless even without a surgical operation. In fact, the majority of cases go on to a recovery. Nature is able to bring about a recovery, and we should always remember how it is done—that the peritonitis that is excited thereby becomes limited in extent; that an inflammatory wall is thrown up about the appendix, which limits the peritonitis and makes it circumscribed rather than general. That wall is by the surgeon found to be made up by the coils of intestine, agglutinated together by the inflammation. When pus is formed after this occurs, it will be as a circumscribed collection, and is occasionally evacuated through the abdominal wall by the surgeon, but, as much more often happens, it makes its escape back into the intestine through the perforation, or by its own action upon the intestinal wall, in which case it is discharged through the rectum and its elimination overlooked for several reasons, one of which is that no one looks for it, and another, that much of it is absorbed before it reaches the anus.

In certain other cases the termination is not so fortunate. They do not discharge through the external abdominal wall nor the intestinal canal, but the ulcerative process is directed in the other way between the coils of the intestine, and the newly-formed material, which binds the coils of intestine together, breaks down before the ulcerating action of the pus, discharging the pus into the free peritoneal cavity. It is when this occurs that we have the severe case with the shock and falling temperature—temperature falling below normal, the pulse becoming very weak, and in this state of collapse the patient dies. In such a condition the physician says the patient did not die of peritonitis or septic poisoning, or from inflammatory action, because the temperature instead of being high was subnormal. He does not take into account the fact that pus is developed in large quantities; that it is virulent in character; and that when it is poured into the free peritoneal cavity, the greatest absorbent in the body, its ptomaines are taken up immediately in such an immense dosage as to completely paralyze the heat centers; and that the patient sinks under this vast dose of poison without ever sufficiently rallying for the temperature to rise above the normal point. This case I have met with several times and the only rational treatment is to open the abdomen immediately without waiting for anything more than the most necessary preparations. Wash out the peritoneal cavity, make the necessary repair and provide free drainage. From the experience of more than fifteen years in abdominal surgery, I am led to state that no case is too severe or too near death to be operated upon. I have not had a death in any of the cases which I have operated upon for over ten years, and I have operated upon only severe cases. I have not selected the cases, but have taken a conservative view of mild or ordinarily-severe cases and allow them to proceed according to the plans of nature, trusting to nature for the cure. As illustrations of different forms of appendicitis, I shall give three cases:

1. A case of perforative appendicitis with a general suppurative peritonitis.

M. S. is a little girl ten years old. Four years ago she was sick for ten weeks with typhoid fever. At one time during the course of the fever there was an obstruction

of the bowels which lasted fifteen days, after which the bowels moved spontaneously, followed by diarrhœa. Since that time she has had more or less intestinal difficulty, irregular movements, and so much pain in the abdomen that it was impossible for her to run and play with other children. I saw the patient first in consultation December 21, 1891. I found the child suffering with peritonitis, having been in that condition for ten days. Gas was passing from her bowels, but no fæcal matter, an indication that the obstruction was not complete. On deep pressure, an indistinct tumor could be made out in the right iliac fossa. Morphine had been given continuously from the beginning of the peritonitis. It was withdrawn and epsom salts substituted and given regularly for twenty-four hours. The salts had no effect upon the bowels, but induced vomiting and great pain. At the end of twenty-four hours I saw the patient again, administered morphine to quiet her during the night, and decided to operate the next morning, though the prognosis was very unfavorable owing to the weakness of the patient. The diagnosis was narrowed down to a strangulation by a band or a perforated appendix. A median incision was made four inches in length. The colon was examined, and some fæcal masses, hardened balls as large as goose eggs, were broken up and passed into the rectum. Across the head of the colon I found a band made up of the tail of the appendix, involved omentum and old adhesive material. Between the band and the intestine I could pass the point of my finger so that the stricture was not complete. The band was cut between two ligatures, a perforation of the appendix was found, and consequently the appendix was ligatured and amputated. A large quantity of pus was washed out of the free peritoneal cavity, a glass drainage tube was put in near the site of the stump of the amputated appendix and the abdomen closed.

The child rallied well from the operation, and there was little shock. Calomel per orum and salts per rectum were administered the first night and a movement of the bowels obtained before morning. Her bowels continued to move at intervals of a few hours thereafter. Nourishment was taken and retained, and champagne given frequently. The peritonitis was met by salts. The second night the patient's temperature and pulse rose, pain was very severe and little sleep was obtained. In the morning her pulse was 140, temperature 102, and the prognosis very grave on account of increasing weakness and failing heart; nourishment continued to be retained. Raw egg and milk with whisky was administered every six hours, and in twenty-four hours more the indications were much more favorable. Four days later the glass tube was removed and a rubber one put in its place. The wound suppurated and small sloughs were discharged from the tube. The treatment with salts was continued. The patient continued to improve, her appetite increased and no unfavorable symptoms appeared. The wound was dressed daily and healed by granulation.

February 10: Six weeks after the operation a letter was received from the child itself, saying that she was almost well, and that she had already walked across the street to a neighbor's.

Later: The patient made a slow, but complete recovery, and has none of her old abdominal or intestinal difficulty.

2. A case of perforation of the posterior wall and on through the iliac fascia into post-peritoneal tissue.

A man about fifty-five years of age, a patient of Drs. Klippel & Wetherby, of Hutchinson, Kansas, who had made a diagnosis of appendicitis, and had watched the case during the preceding week. But when I saw the case it was so masked that it seemed impossible to think that all the symptoms were due to the appendicitis, and it was only by a process of exclusion, by examining all the organs of the body from the brain downward, that I arrived at the conclusion that the diagnosis was correct. The case presented such peculiar symptoms that I could hardly pursuade myself that there was not some disease of the brain or cord. The nervous symptoms, as well as other general

symptoms found in the case, were later proven to be dependent upon septic absorption from the iliac abscess, as they all disappeared upon evacuation of the same. I was out of town when the telegram from the doctors was received, and was consequently delayed in reaching the bedside. When I did arrive the patient seemed to be in a hopeless condition. He was delirious, his pulse seemingly down to the lowest limit compatible with life, and I gave a very unfavorable prognosis of the case; but, after confirming the diagnosis of the physicians, I advised an operation. This was readily consented to, and with as little delay as possible the abdomen was opened on the right side. The intestines were found congested, but nothing further; no agglutination, but on passing back to the iliac fascia it was found to be as tense as though made of sheet iron, and quite full in comparison with the normal condition found on the opposite side. It was punctured with a groove director, and a drop of pus welled up along the groove; this was sufficient evidence of the existence of a pus cavity. The abdominal incision was enlarged from two to three inches, gauze sponges packed about to protect the intestines and free peritoneal cavity, the abdominal wall depressed, when the iliac fascia was carefully and widely opened. Nearly a pint of foul smelling, sickening pus was evacuated from the cavity which was found to have extended in different directions, notably into the pelvis. This was washed out rapidly, drainage tube inserted, the Mikulicz gauze packing was inserted to the bottom of the cavity, the gauze sponges removed, the intestine coiled about the gauze packing and secured by a few stitches to the abdominal wall, and no attempt was made to find or remove the appendix owing to the low condition of the patient; a few hours later the tube was removed and the gauze was left to provide permanent drainage. The patient was put to bed, when a most surprising diaphoresis occurred, lasting a few hours. From that improvement occurred, going on to a complete recovery.

3. A case of strangulation with gangrene of the appendix, ilium and cæcum.

This last case was one of recurring appendicitis, the present attack being the seventh that had occurred within three years. This case was brought to me from Kansas City, Missouri. I advised operation, telling the patient the risk of operation was much less than the risk from the recurring attacks of the disease. The patient was in good condition, and I waited until the following day in order to have an aseptic operation; opened the abdomen in the right side, drew out the cæcum and appendix, which were no where adherent. The external surface of the cæcum was black and gangrenous, the appendix completely so. On picking it up to see if it could be ligated, it easily broke off from its attachment to the cæcum. I attempted to introduce sutures to close the opening, but in doing so I found that I would narrow the lumen of the gut to a dangerous extent if I brought the two peritoneal surfaces together. A portion of the ilium which had laid next the appendix was also gangrenous, and it seemed out of the question to do an anastomotic operation. I therefore brought the gangrenous spots to the abdominal incision, where I secured them with sutures, closed the upper angle of the wound and packed the lower angle of the wound next the intestine with iodoform gauze. Fæces were discharged from the wound, daily dressings were required and a fæcal fistula remained for about eight weeks which closed spontaneously. The patient has made an apparently complete recovery.

J. C. McClintock.

NEW REMEDIES.

Herpes Zoster.

Dr. Ohmann Dumesnil, in a valuable article on Herpes Zoster in the *Quar. Atlas of Derm.*, recommends Peacock's Bromides as a nerve sedative when the prodromic symptoms appear.

Europhen in Skin Transplantation.

Dr. Trnka, a military surgeon, calls attention to the fact that the excellent results of Thiersch's method of skin transplantation are frequently much impaired by the circumstance that in consequence of the dressing employed the skin grafts become detached from the wound surface or are floated away by the secretions. He has therefore sought to improve the dressings commonly employed, such as silk protective, gold beaters skin, gutta percha, but always without success, for even during the most careful removal of the dressings in the most quiet patients, some of the transplanted pieces were detached or displaced. He observed, however, that in protracted operations of this kind on large wound surfaces the pieces first transplanted adhere very firmly if they, as well as the wound, had been dried by the air and become covered with a fine coagulation pillicui. For this reason he allowed the wound to dry exposed and uncovered for one to three hours after the operation, or blew air on it with a rubber bulb or fan, the operating room being rendered as thoroughly aseptic as possible. It was found now that the grafts adhered firmly, even when there was profuse secretion from the wound surface, and later are as of healthy and vigorous epithelium, raised above the surface of the wound, developed which rapidly extended. It was also noted that a desquamation of the most superficial layer and most external margin took place after firm union of even the most thinly-cut grafts. If the transplanted pieces of skin were well dried they assumed a glassy, diaphanous appearance.

With the object of diminishing the wound secretion as much as possible and of preventing the detachment and maceration of the grafts, the author resorted to dry dressing with Europhen, which in his hands had proved extremely serviceable as an application to dry up secretions and stimulate the formation of epithelium. The resinous, extremely fine and light Europhen powder combines intimately with that portion of the wound surface which is covered with the grafts, forming a firm wall and protective covering over the transplanted tissue, which is not affected chemically or disturbed in its vital functions. The Europhen is dusted on with a brush, or, better still, is insufflated with a glass tube or drainage tube, until it forms a thin layer through which the transplanted skin particles are visible, and over it is applied a piece of very fine gutta percha tissue, thinly covered with white vaseline. The gutta percha is cut about an inch broader than the wound surface, is fixed firmly to the skin with chloroform after a few wicks have been inserted beneath it for purpose of drainage. Over this is placed a layer of soft wood wool, then a layer of cotton and an organtin bandage. The dressings are not allowed to remain on long — at the most, two days — and the above procedure is followed with each change of dressings. The author observed that under the silk and gutta percha dressing the callous stratified epithelial ring at the wound margin, which always formed under dressings of gauze or ointments, never occurred; on the contrary, the epithelium remained soft and rapidly extended from this place.

The procedure here described of combining exsiccation of the wound with the Europhen dressing has proved extremely useful in numerous cases of transplantation, and can be readily carried out on all portions of the body. It considerably lightens the otherwise laborious after-treatment.— *Wiener Medizinische Wochenschrift*, No. 18, 1893.

I AM glad to state that I have formed a high opinion with Cactina Pillets. One case in which I tried them was an old gentleman who has been suffering for years from valvular disease of the heart, and who for over four years has never been able to leave off taking some form of heart tonic. Latterly he had been taking strophanthus, but a month ago it brought on diarrhœa, and we had to leave it off. Digitalis he could not take, and having tried strychnia and various other remedies without doing any good, I

resorted to Cactina Pillets. I gave him a bottle of 100 pillets, and marked improvement resulted, and since then he has taken more. He himself says he is stronger and better than he has been for years, for proof of which is that he can now walk about his grounds, whereas he formerly had to be wheeled in a bath chair. One of my favorite prescriptions is the following:

℞

Cactina pillets.....20
Ammon. carb.....30 grains.
Spts. chloroform.....1½ drams.
Tinct. columbæ.....2 drams.
Aquæ q. s. ad.....8 ounces.

T. GORDON KELLY, M.D., A.B.,
The Priory, Desford, Leicester, Eng.

DR. J. W. DREW, of Mondamin, Iowa, writes as follows: "I submit the following combinations, which in my judgment are desirable:

FOR MIGRAINE.

℞

Antikamnia.....2½ grs.
Camph. monobrom....½ gr.
Caffeine cit.....½ gr.

FOR NEURALGIA.

℞

Antikamnia.....2 grs.
Quiniæ sulph.....½ gr.
Strychnia sulph.....1-100 gr.
Aconitin.....1-500 gr.
Hyoscymin.....1-200 gr.

BRONCHIAL.

℞

Antikamnia.....2 grs.
Tartar emetic.....1-40 gr.
Ol. capsicum.....1-40 gr.
Sanguinarine nitr....1-60 gr.
Strychnia sulph.....1-150 gr.
Strophanthine.....1-500 gr.

"Each of the above formula are for one dose, to be administered as the attending physician may find indicated."

ADVERTISE in the JOURNAL.

Piperazine.*

BY W. MAJERT AND A. SCHMIDT.

Erroneous statements have appeared in several modern text-books regarding the physical and chemical characters of piperazine, $C_4H_{10}N_2$, which have been confused with those ascribed by A. W. von Hofmann and by Ladenburg to the impure substances of like composition discovered by them, and termed respectively diethylenediamine and ethyleneimine or diethylenediimine; our attention has been directed to the fact that this misunderstanding has partly arisen from a misconstruction of our views (*Ber.*, 1890, 3719) as to the identity of these substances; we therefore desire to correct this impression.

Piperazine, which was not known in its pure crystalline condition until prepared by us in August, 1890, by treatment of dinitrosodiphenylpiperazine with alkali, is a crystalline substance melting at 104–107° in capillary tubes, although when the melting point is determined on large quantities it is found to be 112°, the differences being due to the hygroscopic nature of the base; it boils at 140–145°. It is very readily soluble in water and alcohol, the aqueous solution having a distinctively alkaline action. It is very hygroscopic and readily absorbs carbon dioxide, being thereby converted into the carbonate, melting at 162–165°.

Piperazine is especially characterized by the formation of an insoluble pomegranate red double salt with bismuth iodide and by a dibenzoyl compound, melting at 191°.

The basic substance diethylenediamine, prepared by Hofmann by the interaction of ammonia and ethylene bromide, consisted of a liquid mixture of bases, boiling approximately at 170°. That this mixture contained a small quantity of a base identical with piperazine is undoubted, but it was only after piperazine had been prepared from dinitrosodiphenylpiperazine that Hofmann succeeded in identifying it and isolating the pure crystalline product from the mixture, which, besides higher ethylene

bases, contained a number of vinyl compounds.

Owing to the difficulty of purifying small quantities of the base, Ladenburg's experiments with diethylenediamine, obtained by the decomposition by heat of ethylenediamine hydrochloride, were unsuccessful: the product described by Ladenburg as the base was undoubtedly impure piperazine carbonate, as proved by its melting point, 159–163°.

In conclusion, it may be interesting to mention that we have succeeded in preparing the following series of hydrates of piperazine, that most readily formed being a hexhydrate which crystallizes from dilute aqueous solutions:

$C_4H_{10}N_2H_2O$, m. p. 75°,
" $_2H_2O$, " 56°,
" $_3H_2O$, " 39–40°,
" $_4H_2O$, " 42–43°,
" $_5H_2O$, " 45°,
" $_6H_2O$, " 48°.

* Chem. News, March 3, 1893, p. 108; from a paper read before the Chemical Society.—Amer. Jour. Phar., April, 1893.

THE annual meeting of the Medical Society of the Missouri Valley will be held in Council Bluffs, Iowa, September 21st (Thursday) and continue in session one day. Members contributing papers must send titles to the secretary prior to August 25th, so they can appear on printed program, mailed September 1st. Applications for membership can be sent to Dr. J. F. White, Council Bluffs, Iowa, with a fee of two dollars enclosed.

A full meeting is expected; a profitable session desired.

F. S. THOMAS, M.D.,
Secretary.

Chloralamid.

Chloralamid is one of the most recent hypnotics, and, judging by our experience up to this time, one of the most useful. It has a slightly bitter taste, and is not readily soluble in water, but it is promptly dissolved in alcohol. It appears to have no injurious action on the heart or respiration. The sleep that it produces is refreshing, and not so profound but that the subject wakes once or twice in the course of the night for a moment or two. It seems to be a pure hypnotic, no other marked effect upon the organs of the body besides the brain having as yet been observed. It simply contracts the cerebral bloodvessels, diminishing the amount of blood circulating in the substance of the brain and thus producing sleep. It begins to act within half an hour. It is a hypnotic even in the case of those persons who are the subjects of acute pain, and would, therefore, otherwise pass the night in great discomfort.—William A. Hammond, M.D., in the *North American Review.*

Carcinoma.

When we meet with cancer that is unsuitable for operation, the Elixir Six Iodides (W. G's.) may be employed with benefit more especially if the ulcerated stage has not set in.

DR. W. C. ABALY says: "I have used the Three Chlorides, R. & H., with marked success in syphilitic iritis, tertiary syphilis with anæmia. As a tonic alterative and for various conditions in which mercury, iron and arsenic are indicated in a palatable form I take great pleasure in recommending it to brother practitioners."

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